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PAIN AND FUNCTIONAL CAPACITY IN MEN ATTENDED TO AT A HEALTH CENTER

DOR E CAPACIDADE FUNCIONAL EM HOMENS ATENDIDOS EM UM CENTRO DE SAÚDE DOLOR Y CAPACIDAD FUNCIONAL EN HOMBRES SE REUNIERON EN UN CENTRO DE SALUD

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ABSTRACT

Objective: to determine the factors that interfere in the men's pain. **Method:** descriptive, cross-sectional, quantitative approach. A questionnaire was applied to men attended to at a Health Center, containing socio-demographic data, life habits and clinical/anthropometric data. Pain and functional capacity were investigated using the SF-36 questionnaire. **Results:** in the functional capacity and pain domains, mean values were 63.7 ($\pm$ 22.5) and 78.1 ($\pm$ 26.9), respectively. Analyzing the relationship of pain with socio-demographic, clinical and lifestyle data, there was a statistically significant difference in lifestyle, with alcoholism (p 0.0201) and level of physical activity (p 0.0409) and clinical data with a diagnosis of diabetes (p 0.0403), glycemic levels (p 0.0039) and blood pressure levels (p 0.0202). **Conclusion:** the factors that interfere in the men's pain studied were, age, alcohol consumption, level of physical activity, presence of diabetes, and blood glucose and blood pressure levels. **Descriptors:** Pain; Man; Work Capacity Evaluation.

RESUMO

Objetivo: determinar os fatores que interferem na dor de homens. **Método:** estudo descritivo, transversal, de abordagem quantitativa. Aplicou-se um questionário a homens atendidos em um Centro de Saúde contendo dados sociodemográficos, hábitos de vida e dados clínicos/antropométricos. A dor e a capacidade funcional foram investigadas por meio do questionário SF-36. **Resultados:** nos domínios capacidade funcional e dor, houve média de 63,7 ($\pm$ 22,5) e 78,1 ($\pm$ 26,9), respectivamente. Analisando a relação da dor com dados sociodemográficos, clínicos e estilo de vida, houve diferença estatisticamente significativa no estilo de vida com etilismo (p 0,0201) e nível de atividade física (p 0,0409) e dados clínicos com diagnóstico de diabetes (p 0,0403), níveis glicêmicos (p 0,0039) e níveis pressóricos (p 0,0202). **Conclusão:** os fatores que interferem na dor dos homens pesquisados foram idade, etilismo, nível de atividade física, presença de diabetes e níveis glicêmicos e pressóricos. **Descritores:** Dor; Homens; Avaliação da Capacidade de Trabalho.

RESUMEN

Objetivo: determinar los factores que interfieren con el dolor de los hombres. **Método:** estudio descriptivo, transversal, enfoque cuantitativo. Aplica un cuestionario que los hombres se reunieron en un centro de salud, que contiene datos demográficos, hábitos de vida, y datos clínico/Anthropometrical. Se investigaron el dolor y la capacidad funcional mediante el cuestionario SF-36. **Resultados:** en las áreas de capacidad funcional y dolor un promedio de 63.7 ($\pm$ 22.5) y 78.1 ($\pm$ 26.9), respectivamente. Analizar la relación de datos demográficos, clínico dolor y estilo de vida que existió diferencia estadísticamente significativa en el estilo de vida, con el alcoholismo (p 0.0201) y nivel de actividad física (p 0.0409) y datos clínicos con diagnóstico de diabetes (p 0.0403), los niveles de glucosa (p 0.0039) y la presión arterial (p 0.0202). **Conclusión:** los factores que interfieren con el dolor de los hombres encuestados fueron edad, alcoholismo, nivel de actividad física, presencia de diabetes y los niveles de glucosa y presión arterial. **Descriptores:** Dolor; Hombres; Evaluación de Capacidad de Trabajo.

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INTRODUCTION

According to the International Association for the Study of Pain, pain is an unpleasant multidimensional experience, involving not only a sensory component, but also an emotional one, which is associated with a concrete or potential tissue injury, or is described as a function of this lesion, basic human needs, work activities, relationships and emotions, and can lead to life's hopelessness. It is one of the main causes of human suffering, undoubtedly one of the most intimate and unique sensations experienced by the human being.¹

Pain² is a negative experience in human life; it represents a public health problem, considering its physical and emotional consequences, which can result in temporary or permanent anxiety and disability. Currently, pain has been the source of debates and meetings of great relevance in the world, being considered fifth vital sign and having great influence on people's lives.

In this way, the interpretation of pain varies from individual to individual, as well as in the same, at different times of their life, under different circumstances. With regard to gender, women deal better with pain. These are more affected by facial pain, Fibromyalgia, repetitive strain injury, migraine, multiple sclerosis. Men already suffer more from cancer, limb amputation, ischemic conditions and encephalopathies.³

Pain in patients submitted to chemotherapy was studied in 2012 in Imperatriz (MA), Brazil, and a female majority of 74.7% was identified⁴. A study conducted in 2013 in elderly people with chronic pain residents in the State of São Paulo showed a majority of the female population, with 59.6%. A survey on pain and functionality in Primary Care in the state of Rio Grande do Norte in 2011, reported the majority of women affected by pain, where 81.25% of them reported pain in the last seven days.

Research in Portugal, in 2011, on indirect costs of chronic pain in the financial market also shows the female population as the most affected, reaching up to 50 million Euros in costs between 50 and 54 years of age.⁵

Swedish study analyzed the epidemiology, comorbidity and impact on the health-related quality of life of self-reported headache and musculoskeletal pain from the point of view of gender. They studied the prevalence of painful conditions, especially headache, and found that it is higher in women, who also reported more severe pain.

The incidence of comorbidities in painful conditions and psychiatric or somatic problems were higher in women.

The higher prevalence of pain among women is due to the hormonal variations that have occurred. It is admitted that there are differences, also in the responses to the treatment of pain. It is explained that, because women are responsible for a higher prevalence in cases of pain, they use more analgesics.²

We see that the main causes of pain are directly related to some defined pathologies and emotional aspects (most of the time, both causes cited), and daily life (this includes working hours, type of work, posture, being sedentary, eating habits). The improvement of the pain symptom occurs, primarily, through the identification of the cause and its evaluation.

The classification of pain can be by the duration of its manifestation as acute, chronic and recurrent pain (SBED - Brazilian Society for the Study of Pain). In an allergic picture there are verbal or codified reports and appetite changes. Acute pain is identified through: antalgic position; facial expressions; sleep disturbances; dejected appearance among others.²

Pain assessment has a subjective and personal component. The instruments used are questionnaires and indexes. These can be classified into: one-dimensional or multidimensional. The so-called one-dimensional analyzes only one characteristic, usually, the intensity. Multidimensional assess pain in more than one dimension.⁶

Health-related quality of life (HRQoL) was different between genders and types of pain. The physical dimensions of HRQoL were more affected by headache in men, while the psychological dimensions were more affected in women. In both sexes, Ador was associated with worse socioeconomic conditions and lifestyle factors, but there were gender differences.⁷

Knowing the main factors that affect a particular population, especially in men, since they are the ones who seek health services the least, leaving an open space for questioning, instigates us to research and learn about the relationship between the pain symptom and the male sex. This work is justified by the interest in bringing new data and indexes, aiming at an improvement in care and seeking to solve problems that affect the patients' daily lives.

OBJECTIVE

- To determine the factors that interfere with the pain of men treated at a health center.

METHOD

A descriptive, cross-sectional study of a quantitative approach, developed with data from patients from the research entitled "Living and health conditions of users attended at the Liberdade Health Center".

Were included, in this study, all men aged 18 years or over, who agreed to participate in the study and were enrolled in the unit. Patients with chronic diseases (cancer and acquired immunodeficiency syndrome) were not included in the study.

Data collection took place from March to April 2014. Men in the Health Unit who were waiting in line for medical or Nursing consultations were approached. Clarification was provided on the study regarding the aspects of privacy and confidentiality of the information, assuring the right to withdraw participation at any time and the Free and Informed Consent Form was signed by those who agreed to participate in the research.

A questionnaire developed specifically for this study was applied, based on existing literature, containing socio-demographic data, life habits, clinical / anthropometric data, pain and functional capacity.

The socio-demographic data investigated were: age categorized in 18 to 59 years and ≥ 60 years; skin color was self-reported, categorized in white and non-white; marital status; study time in years and average income. The criterion of economic classification was according to the ABEP (Association of Brazilian Companies of Research), categorized in Classes A, B, C, D and E.

With regard to the lifestyle, was evaluated smoking, alcoholism and being sedentary. Smoking was considered to be all men who smoked or had quit smoking and the alcoholic who, at the time of the interview, reported using alcohol, regardless of quantity and frequency. The level of physical activity was assessed by the International Physical Activity Questionnaire (IPAQ®), developed by the World Health Organization (WHO), that addresses a standardized tool for physical activity practices. The level of physical activity was established in sedentary and active.

The anthropometric data (weight and height) were collected according to the

method proposed by Gordon et al.: Weight (in kilograms); Height (in centimeters); and CC (waist circumference) and RQC (hip waist ratio). The body weight was collected by a platform-type electronic scale with a capacity of 150 kg and a graduation in 100 g (CAUFAQ® EB 1003). For stature, the stadiometer (SECA) was used with a scale in millimeters, fixed to the wall. By means of the body mass ratio by the squared stature of the individuals, the Body Mass Index was calculated. The BMI values were categorized by nutritional status, according to the World Health Organization proposal, following the cutoff points: normal: between 18.5 and 24.99 kg / m²; Overweight: 25 to 29.99 kg / m²; Obesity: over 30 kg / m².

To measure the waist and hip circumference, an inelastic tape measuring in centimeters from zero to 1.90cm was used. The cut-off points adopted were 102 cm. With these measurements, the waist/hip ratio was calculated, whose cutoff points were above 0.95.

After the identification and socio-demographic data collection, blood pressure was measured in the left upper limb. Blood pressure was measured using a digital sphygmomanometer (Omron®), by indirect method, with the patient at rest, in a seated position.

The capillary glycemia was verified with a glucose meter (ACCU-CHEK ACTIVE®), which makes the determination of fresh capillary blood glucose by reflectance photometry. This device is capable of detecting capillary glycemia between 10 mg / dl and 600 mg / dl. Values for fasting blood glucose (below 60 mg / dl - hypoglycemia, 60 to 100 mg / dl - normoglycemic, 101 to 125 - hyperglycemic, ≥ 126 diabetic) and for postprandial glycemia (up to 199 mg / dl normoglycemic, ≥ 200 mg / dl hyperglycemic or decompensated diabetic). Subsequently, this variable was re-categorized in a controlled or altered form. In addition, the time of hypertension and diabetes was verified.

To evaluate pain and functional capacity, items from the Short Form - 36 questionnaire (SF - 36) were extracted.

The SF-36 is a multidimensional questionnaire consisting of 36 items, encompassing eight scales or components: functional capacity (ten items), physical aspects (four items), pain (two items), general health status (four items), social aspects (two items), emotional aspects (three items), mental health (five items) and a comparative evaluation question between current health conditions and a year ago. In this way, it evaluates both negative aspects of health

(disease or illness) and positive aspects (well-being). The data are evaluated from the transformation of the answers into scale scores of zero to 100, of each component, not having a single value that summarizes the whole evaluation, resulting in a better or worse overall health status.

For the SF-36 domains selected for the research, such as: pain and functional capacity, these were coded and transformed into scales from zero to 100 points, using scoring and own interpretation of the scale. Thus, an average score is obtained: the highest score indicates better health status or quality of life and the smaller scores, worse situation or impaired quality of life. The calculation of the SF-36 scores produces a result called Raw Scale because the final value does not have any units in measure. Still with regard to pain, the pain localization and the quantification of pain were questioned on a numerical scale ranging from zero to 10.

Qualitative variables are presented in tables with frequencies and percentages, quantitative variables in means and standard deviation. The association of the general health status score with sociodemographic, life, anthropometric and clinical characteristics were performed using the Man-Whitney or Kruskal Wallis tests, followed by Newman-Keuls tests.

The normality of the quantitative data was tested using the Shapiro Wilker test. The significance level was set at 5%, ie all associations that p-value less than 0.05 were considered statistically significant. Data processing and analysis were performed in the 12th version of STATA (Data Analysis and Statistical Software).

This study complies with CNS Resolution No. 466/12 of the National Health Council / MS and obtained approval of the research project by the Research Ethics Committee - CEUMA University, under protocol 467.318 / 2013.

RESULTS

A total of 202 men participated in the study, of a total sample 646 users, totaling 31.2% of the total sample, with no data collection losses, either due to lack of information or refusal to participate in the study.

There was a prevalence of men aged between 18 and 59 years (57.4%); mean age 57.8 ($\pm$ 17.30); married (51.5%); (brown and blacks 83.2%); with average schooling of five to eight years (36.6%) and average income of two to four minimum wages (R\$: 2,256.00) (39.1%).

Table 1. Socio-demographic characteristics of men attended at the Liberdade Health Center. São Luís (MA), Brazil, 2015.

Variables (n=202)	n	%
Age group		
18 to 59 years	116	57.4
≥ 60 years	86	42.6
Conjugal Situation		
Married / Consensual Union	104	51.5
Not married	61	30.2
Separated / Divorced	21	10.4
Widower	16	7.90
Color		
White	34	16.8
Not white	168	83.2
Education		
Illiterate	28	13.8
1 to 4 years	47	23.2
5 to 8 years	64	36.6
9 to 12 years	52	25.7
Above 12 years	11	0.70
Family income		
Up to 1/2 minimum wage *	13	6.40
1/2 to 1 minimum wage	26	12.8
1 to 2 minimum wages	49	24.2
2 to 4 minimum wages	79	39.1
Above 4 min wages.	35	17.5
Total	202	100

* - Minimum salary of \$ 678.00

It was observed that the lifestyle that prevails in men who do not have smoking habits (70.3%), however, had alcoholic habits (63.8%) and were inactive for physical activity - IPAQ (36.6%). Clinical data indicated that they were not diabetic (68.3%), however, glycemic levels were altered (≥ 110 mg / dl (65.3%). Most did not report arterial hypertension (62.8%), but presented Altered blood pressure levels ($BP \geq 139 \times 99$ mmHg) (51.1%). In the anthropometry, men with overweight BMI (49.0%) were detected, Normal Waist Circumference (79.2%) and Normal Waist / Hip Ratio (72.3%).

Table 2. Lifestyle, anthropometry and clinical characteristics of men attended at the Liberdade Health Center. São Luís (MA), Brazil, 2015.

Variables (n=202)	n	%
Smoking		
Absent	142	70.3
Gift	60	29.7
Ethicism		
Absent	73	36.2
Gift	129	63.8
Physical Activity - IPAQ		
Sedentary	46	22.8
Inactive	74	36.6
Irregularly active	57	28.2
Active	25	12.4
Diabetes		
No	138	68.3
Yes	64	31.7
Glycemic Levels		
Controlled	70	34.7
Altered	132	65.3
Arterial hypertension		
Yes	75	37.2
No	127	62.8
Pressure Levels		
Normal	76	37.6
Bordering	23	11.3
Altered	103	51.1
Body mass index		
Suitable	54	26.8
Overweight	99	49.0
Obesity	49	24.2
Waist circumference		
<102 (Normal)	158	79.2
≥ 102 (Risk)	42	20.8
Waist / Hip Ratio		
<0.95 (Normal)	146	72.3
≥ 0.95 (Risk)	56	27.7
Total	202	100

Regarding the means, standard deviation, maximum and minimum values of the functional capacity and pain domains, there was an average of 63.7 (± 22.5) for functional capacity and an average of 78.1 (± 26.9) for pain.

Table 3. Score of the domains Functional Pain Capacity of the SF-36 Questionnaire of men attended at the Liberdade Health Center. São Luís (MA), Brazil, 2015.

Domain(n=202)	Average	Standard deviation	Minimum	Maximum
Functional capacity	63.7	2	1	100
Pain	78.1	26.9	0	100

There was also the relation between age group and functional capacity domains (p 0.005) and pain (p 0.0012), both statistically significant for the study.

Table 4. Association of the pain domains and functional capacity of the SF-36 questionnaire by age group in men attended at the Liberdade Health Center. São Luís (MA), Brazil, 2015.

Functional Capacity				Pain		
Age group	Average	Standard deviation	P value	Average	Standard deviation	P value
18 - 59 years	87.0	20.3	0.0055	67.4	24.9	0.0012
≥60 years	57.5	20.6		73.3	21.6	

*Mann-Whitney

When analyzing the association of the pain domain with socio-demographic data, lifestyle, anthropometry and clinical data in table V, were found that there was a statistically significant difference in lifestyle with alcoholism (p 0.0201) and level of physical activity (p 0.0409) and clinical data with a diagnosis of diabetes (p 0.0403), glycemic levels (p 0.0039) and blood pressure levels (p 0.0202).

Table 5. Association of pain domain and sociodemographic, anthropometric and clinical characteristics of men attended at the Liberdade Health Center. São Luís (MA), Brazil, 2015.

	Pain Average	Standard deviation	P-Value
Race			0.3534 ^a
White		20.7	
Not white	75.7	27.8	
Education			0.3200 ^b
Illiterate	60.0	32.7	
1-4 years	66.7	26.7	
5-8 years	83.1	22.4	
9-12 years	75.1	28.3	
> 12 years	87.1	20.7	
Smoking			0.3403 ^a
Absent	78.04	24.65	
Gifts	72.65	30.32	
Ethicism			0.0201 ^a
Absent	53.8	28.3	
Gift	77.5	25.8	
Physical Activity Level - IPAC			0.0409 ^b
Sedentary	77.9	23.2	
Inactive	75.1	28.3	
Irregularly active	55.0	27.8	
Active	50.6	57.1	
Waist / Hip Ratio			0.6297 ^a
<0.95 (Normal)	76.2	28.1	
> 0.95 (Amended)	75.6	24.4	
Diabetes			0.0403 ^a
Yes	59.9	23.4	
No	79.8	30.1	
Glycemic levels			0.0039 ^a
Controlled	55.4	21.7	
Changed	78.3	21.8	
Arterial hypertension			0.4001 ^a
Yes	60.8	38.6	
No	67.9	34.9	
Pressure Levels			0.0202 ^b
Normal	48.8	24.1	
Bordering	68.9	23.9	
Altered	80.7	21.8	

a-Mann Whitney; b - KruskalWallis(Newman-Keuls: I >i)

DISCUSSION

Pain is something felt by the individual and not visualized. During the last decade, pain has become an important treatment factor, seen as a basic human right and not just as a clinical condition. There is, however, little information describing this population of health users, and the impact that this new demand has on the use of health services⁸.

It affects patients with a variety of diseases of varying duration, but, there is a common characteristic: lack of understanding of the facts that initiated or maintained its development and its prevalence.³

Pain is considered a frequent health problem, which causes serious personal and economic damages to the population. Very little is known about the epidemiology of chronic pain in Brazil and in the rest of the world, especially, when it comes to research on the identification of factors of persistent pain.⁸

It was noted that, just as concern for pain is recent, man's health has also been gaining ground recently. Policies aimed at this public seek to increase life expectancy and reduce morbidity and mortality rates from preventable and preventable causes in this population.⁹

The Human Health Policy is aligned with the National Primary Care Policy, the gateway to the Unified Health System, with humanization strategies, and in line with UHS principles, strengthening actions and services in networks and health care.⁹

The male presence in search of health services is still quite reduced. Educational campaigns that show the importance of human health are constantly growing, aiming for frequent care, enabling health care to reduce problems such as hypertension and diabetes and early diagnosis of cancer.

A possible justification for the low demand of men in health care may be related to the view that still has of man as being invulnerable, therefore, without preventive attitudes, since to seek the health service could relate it to the fragility. Another aspect, the fear of knowing that you may be sick, as well as the shame of exposing your body may also prevail.¹⁰

This study aims to determine the factors that interfere in the pain of the men treated in a health service. When analyzing the results found, in the face of the fact that pain, despite being such a significant factor in the life of individuals, did not interfere with the functional capacity, and, consequently, in the

labor and daily activities of the men studied. Most of the sample of this study 78.1 ($\pm$ 26.9) did not report pain. Other results¹¹ did not corroborate this research, where the majority of those surveyed with pain presented moderate disability. The findings can be justified by the fact that the men we studied are, in most cases, economically active, and did not report pain.

In a research on applicability of pain scales, 35.6 years were found as mean age of the 60 patients studied, the majority being male (81.6%), which makes us think that the Health Policies of Man In the city surveyed by them - Sorocaba (SP), Brazil - is providing effects, which proves that the male population in the South and Southeast regions is healthier than in the North and Northeast⁶.

The male sample of this study was much lower when purchased from the total of those surveyed. This confirms the idea that men only seek treatment for the health of chronic diseases when they are already in a severe or difficult problem.

Men have a very strong relationship with work and, consequently, with functional capacity. The association between men and work constitutes an elaboration of sociocultural sex and historically instituted. Another aspect that affects men directly, according to the same author, is the fear of becoming ill, a factor that also compromises the functional capacity.

The maintenance of functional capacity is directly associated with the individual's quality of life in maintaining independence in the community, and this is directly related to clinical evaluation.¹²

In this study, when we crossed the age range with functional capacity, results were found that directly influence our sample, because they are statistically significant. For men between 18 and 59 years and those over 60 years of age, there is a functional capacity of 87.0 ($\pm$ 20.3) and 57.5 ($\pm$ 20.6), respectively. When the same age groups were related with pain there are 67.4 ($\pm$ 24.9) and 73.3 ($\pm$ 21.6).

In another study on musculoskeletal pain in health workers¹³, analyzing a sample of workers and doing the same relation, did not find a statistically significant result. For mean functional capacity 89.4 and pain 61.9%, for individuals aged 19 to 34 years, and 85.4 and 69.1 means for functional capacity and pain of individuals aged 45 to 60 years.

This domain is related to men's physical fitness for daily activities and the ability to overcome challenges and stress. It was noted

that age influences considerably, when it is seen in our sample, a majority of men economically active 87.0 ($\pm$ 20.3).

Important results are found when the same age groups were relate to pain, where significant statistics were found. These findings confirm what was expected when there is the relationship with functional capacity, since the latter is related to the quality of life of the individuals.

When asked about pain, the men in our sample, for the most part, did not report it 78.1 ($\pm$ 26.9). Non-equivocal results are found in the Gusmão (2013) study, where the mean pain domain 68.6 ($\pm$ 24.1), makes it clear that pain directly influences the quality of life of the individuals studied.

When the pain domain was related to the variables alcoholism and physical activity level - IPAQ, other studies¹⁵ that addressed a comparison of the clinical-epidemiological profile between men and women in acute coronary syndrome presented similar results, where the presence of alcohol and physical activity are factors which interfere strongly in the quality of life of individuals. Still, the lack of studies that integrate pain and lifestyle was detected.

When analyzing the clinical conditions of the men, it was observed that diabetes mellitus, glycemic levels and blood pressure levels did not interfere with pain, a result similar to the study¹⁶ on the quality of life of patients with chronic pain, where a minority sample with chronic pain reported having diabetes and hypertension. However, this serves as an alert for both the respondents and health professionals, since the studied comorbidities are silent diseases that, several times, with no apparent signs and symptoms. For these and other factors the male population should seek health care frequently, routinely.

It is thought that the main factor that led these men to the health service was not the pain, for being little mentioned, but others, such as accompanying someone and routine appointments. Awareness of the frequency of health care by men could reduce the demand for more aggravating problems.

The sample of this study consisted basically of economically active men, married and with stable union, self-referred nonwhites, with schooling ranging from five to eight years and family income of two to four minimum wages. Clear characteristics of the majority of individuals in the surveyed region, confirming what we thought at the beginning of data collection. Findings that corroborate with those previously found¹⁶, with the exception

of the gender, in their research, the minority was of men (16.1%).

A study¹⁷ carried out on the quality of life of individuals with diabetes mellitus and hypertension revealed that the male population is smaller than the female population, according to the world data, a fact that explains the prevalence of pain among women, also considering the great demand for services Of health by gender, which facilitates diagnosis.

The vast majority of the sample of this study, denied being a smoker. Similar results were found in other studies¹⁷, where, the majority of the groups studied, denied being smokers (71.4%) and (57.1%). This fact brings a sense of tranquility and shows that campaigns against tobacco and other associated policies are having an effect on the population.

Most of the men studied denied having diabetes and hypertension, but, presented altered glycemic and pressure levels, it is recalled that they are comorbidities, on several occasions, silent, and therefore, there is a need for frequent evaluation.

Contrary to the results presented by the study carried out with patients with chronic pain, 16 which makes clear hypertension and diabetes mellitus are the most common comorbidities, they need special attention from health professionals, in order to correctly and assiduously guide the population, since this action is Is essential in guaranteeing patients' quality of life, especially when associated with chronic pain.

It was observed that in the sample studied there was no predominance of pain and that this domain had important alterations regarding life and clinical aspects. The statistically significant factors, that interfere in the pain of the men studied in this study, were age, alcoholism, physical activity level, presence of diabetes and glycemic and blood pressure levels.

The continuous improvement of social conditions is emphasized, mainly through actions aimed at the male public. Consequently, to change the lifestyle of individuals, seeking alternatives for controlling morbidities and other associated factors. In this case, it is necessary to view the extra health center, and the search of these men in their home and work environment, by the visits, lectures and care.

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